

<b>OFFICE USE ONLY</b>	
Cert #	
DOCUMENT CONTROL #	
By _____	



<b>OFFICE USE ONLY</b>	
Remit No.	
By _____	ZZ 708-153

**PLEASE PRINT. INCLUDE A PHOTOCOPY OF YOUR VALID PHOTO ID AND SWORN STATEMENT WHEN SENDING THE REQUEST. Make check or money orders payable to: DSHS - Vital Statistics** All funds are deposited directly to the Texas Comptroller of Public Accounts. For any search of the files where a record is not found, the searching fee is not refundable or transferable.

Birth Certificates			
Type	Cost X	# of copies=	Total
Certified Copy	\$22		
Heirloom-Flag	\$60		
Heirloom-Bassinet	\$60		
(optional) \$8 Lone Star <b>OR</b> \$19.95 USPS Express mail (\$4.95 Priority mail for overseas military address <b>ONLY</b> )			
Expedite fee (required)			\$5.00
<b>Total (Check or money order payable to DSHS)</b>			

Death Certificates			
Type	Cost X	# of copies=	Total
1 <sup>st</sup> Copy	\$20	1	\$20
Additional copies	\$3		
(optional) \$8 Lone Star <b>OR</b> \$19.95 USPS Express Mail (\$4.95 Priority mail for overseas military address <b>ONLY</b> )			
Expedite fee (required)			\$5.00
<b>Total (Check or money order payable to DSHS)</b>			

I wish to make a voluntary contribution of \$5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services.

**BIRTH/DEATH RECORD INFORMATION**

Full Name of Person on Record	First Name	Middle Name	Last Name
Date of Birth/Death	Month	Day	Year
Place of Birth/Death	City or Town	County	State
Full Name of Parent 1	First Name	Middle Name	Maiden Name/Last Name
Full Name of Parent 2	First Name	Middle Name	Maiden Name/Last Name

**REQUESTOR INFORMATION**

Requestor Name	Telephone #	Email Address
Full Mailing Address	Street Address	City State Zip
Relationship to person listed above	Purpose for obtaining this record:	

I authorize mailing to the address below. I have verified that the address below will receive my order.

Name of Person Receiving Copies, if Different from Requestor		
Mailing Address for Copies, if Different from Requestor		
City	State	Zip

**WARNING: IT IS A FELONY TO FALSIFY INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM OR FOR SIGNING A FORM WHICH CONTAINS A FALSE STATEMENT IS 2 TO 10 YEARS IMPRISONMENT AND A FINE OF UP TO \$10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)**

Your Signature \_\_\_\_\_ Date of Application \_\_\_\_\_

**APPLICATIONS WITHOUT SIGNATURE OF APPLICANT WILL NOT BE PROCESSED.**

**MAIL THIS APPLICATION, PAYMENT, SWORN STATEMENT AND A PHOTOCOPY OF YOUR VALID PHOTO ID TO:**  
 Texas Vital Records  
 Department of State Health Services  
 1100 W. 49th Street  
 Austin, TX 78756

**(APPLICATIONS WITHOUT PHOTO ID AND THE ATTACHED SWORN STATEMENT WILL NOT BE PROCESSED)**

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This blank page is to ensure that notarized affidavit (VS-142.3(A)) does not print on the reverse side of the application (VS-142.3).

## NOTARIZED PROOF OF IDENTIFICATION

<b>PART I. ENTER NAME, DATE AND PLACE OF BIRTH/DEATH, AND NAMES OF PARENTS AS INFORMATION APPEARS ON BIRTH/DEATH 79FH-75H9</b>			
FULL NAME OF PERSON ON RECORD		DATE OF BIRTH/DEATH	
PLACE OF BIRTH/DEATH (City or County)			SEX
FULL NAME OF PARENT 1		FULL NAME OF PARENT 2	

<b>PART II. ENTER RELATIONSHIP TO PERSON ON RECORD AND THE TYPE OF ID USED.</b>	
NAME AND RELATIONSHIP TO PERSON ON RECORD	TYPE AND NUMBER OF ID ACCEPTED WHEN NOTARIZED

## AFFIDAVIT OF PERSONAL KNOWLEDGE

<b>PART III. THIS SECTION MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.</b>	
STATE OF _____	
COUNTY OF _____	
Before me on this day appeared _____ (Name)	
} [ _____ (Address) (City) (State)	
who is related to _____ (Relationship)	
I declare the contents of this affidavit are true and correct.	
Signature _____	
Sworn to and subscribed before me, this _____ day of _____, 20 _____.	

(Seal)

Signature of Notary Public
Commission Expires
Typed or Printed Name
Street Address
City, State and Zip

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